Staff Recommendation Regarding FY 2006 Case Mix Distributions and Adjustments Relating to the 1.0% Inpatient to Outpatient Shift

Health Services Cost Review Commission
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The purpose of this paper is to propose an appropriate policy decision by the Commission regarding two issues: 1) the distribution of "unallocated case mix from FY 2006" in the rates of hospitals for FY 2007; and 2) the disposition of the 1.0% shift in FY 2005-06 of revenue from inpatient to outpatient rates. This document is a draft recommendation and is available for comment by the industry. Comments should be submitted in care of Robert Murray, Executive Director, HSCRC, 4160 Patterson Avenue, Baltimore Maryland 21215

Executive Summary

The Commission approved a rate arrangement in April 2006 which reflected a compromise on various positions taken (staff, hospitals, and payers), and directed the industry to outperform the U.S. hospital industry by 1.1% in NOR/EIPA growth over the period FY 2007-2009. This action was based on three factors:

1) it was appropriate for the only rate regulated state in the U.S. to demonstrate its "value-added" to Maryland citizens by once again outperforming the U.S.;

2) it is a long-standing tradition of the HSCRC to moderate the extremes of the nation and in this circumstance begin to prepare for the massive cuts to Medicare spending likely to occur in 2010 to avert insolvency to the Medicare trust fund (projected for 2018); and

3) policy makers in Maryland and across the nation have documented the growing health care affordability problem which is absorbs real wage increases of workers and contributes to the rapid rise in the number of uninsured in the nation.

Since that action taken, staff determined that the Maryland hospital system was not on a path to hit the previously agreed upon NOR/EIPA target for FY 2006. This was due to higher than expected Uncompensated Care and contractual allowances in the system and an unanticipated shift of revenue from inpatient to outpatient revenue stemming from substantial case mix creep and recalibration of unit rates experienced by the two large academic hospitals. This shift of 1.0% of system revenue from inpatient rates to outpatient rates did not change the total bill paid by the public, but it did artificially lower the target measure used as the basis for the FY 2007-2009 rate arrangement.

Failure to account for this 1.0% shift and the resulting artificial improvement in Maryland's inpatient charge position vs. the nation will result in an extra and unintended charge to the public over the next two years. This additional charge could exceed $150 million dollars and result in the Maryland system increasing faster than the U.S. rates of growth over the period FY 2007-2009. Failure to account for the shift is also contrary to approved Commission policy (in 2003) and long-standing Commission policy that mandates that rate realignment should be "budget neutral" for the system.

Staff believes that the action taken by the Commission in April 2006 did not intend this result. The April 2006 action was for a modest 1.1% improvement vs. the U.S. after a period of substantial erosion vs. the U.S. FY 2004-2006 (by design to facilitate the recapitalization of the Maryland hospital industry). Past history of the HSCRC has shown that improvements in excess of 1% per year vs. the U.S. particularly when the U.S. is out of control (as is the current situation given more recent data on the growth in U.S. hospital payments. A 1.1% improvement over 3 years is completely achievable particularly given the cost constraint demonstrated by the Maryland hospital industry in the past two years.

Over the past two months, staff has re-forecasted Maryland's position vs. the U.S. given new information on the rate of growth of hospital charges nationally. This new information indicates that the U.S. situation is even more out of control than previously anticipated. Rates of growth in U.S. hospital charges in FY 2006 will likely approximate 7.0%, far above those originally forecasted. Given our approved rate arrangement, this will substantially increase the projected update factors for FY 2008 and FY 2009 to levels well above the originally projected updates. These increases are appropriate given the April 2006 Commission action, however, it is not appropriate to add to these already large updates (7.07% in 2007, 5.65% in 2008, and 5.64% in 2009) by ignoring the impact of the impact on the paying public of the 1.0% outpatient shift.

The current staff recommended updates (adjusting for the 1.0% outpatient shift as is authorized by the 2003 Commission action for the Rate Arrangement covering the salient period) are more than adequate to continue to improve industry profitability even in the face of alleged wage pressures.

In weighing these options, staff would note several important policy considerations (which will be further substantiated ted in the body of this recommendation):

1) The U.S. hospital growth rates in charges are out of control;

2) Affordability of hospital care should now be a higher priority for the Commission;

3) Commission policy for the FY 2004-2006 rate deal authorized an adjustment for rate realignment (both the second and third rate realignments – revenue shifts discussed in this document);

4) Staff's was consistent and balanced in its approach in 2001 when it "broke" the 2001-2003 rate deal and added 1.0% to the system based on updated facts and circumstances and staff is consistent and balanced again in a similar fashion in the present circumstance ;

5) The current update factors are far above those forecasted in April 2006;

6) The Commission has delivered on its pledge to facilitate the recapitalization of the industry; profits will continue to increase and the unprecedented recapitalization of in excess of $5.0 billion over the Period FY 2004-2010 will indeed occur.

Draft Staff Recommendations for FY 2008 and FY 2009 Update Factors

Background

In April 2006, the Commission acted to improve the position of the Maryland hospital industry on the basis of Net Operating Revenue per Equivalent Inpatient Admission (EIPA), from an anticipated position of 2.0% below the US in FY 2006 to a position of 3.1% below the US in FY 2009.[1] This decision represented a compromise of the various positions put forth by HSCRC staff (recommending an endpoint of 3.5% below the US), the hospitals (recommending remaining at 2.0% below the US), and payers including the Medicaid Program (recommending a more robust improvement to 4.0-4.5% below the U.S.). The Commission's decision represented a modest (by historical Commission performance) 1.1% *improvement* vs. the U.S. over three years.[2]

The stated rationale for this compromise decision was as follows:

1) it was appropriate for Maryland, the only rate regulated State in the U.S., to demonstrate some valued-added vis-a-vis a national cost growth situation which, from a health policy perspective, is considered to be out of control and economically unsustainable;[3]

2) this improvement would be necessary to help Maryland weather the impending massive cuts in the Medicare program likely to occur in 2010 (Maryland has a history of attempting to moderate the volitile policy shifts nationally and chart a more moderate middle course for the hospital industry and the paying public);[4] and

3) there is a growing health care affordability problem in Maryland as evidenced by the rapid growth in the number of uninsured, shortfalls in the Medicaid program requiring the imposition of Medicaid Day Limits (MDLs), and substantial evidence of cost-sharing of health expenditures to employees across employers in the State.

Snapshot of the Industry at the Time of the HSCRC Decision to Improve 1.1% vs. the US

It is clear that the Commission's policy decision in April 2006, to improve 1.1% vs. the U.S. hospital industry over 3 years, was made in the context of a dramatically improved overall revenue and profitability picture for Maryland hospitals. This result was intended by the HSCRC policy decision in FY 2003 which was intended to facilitate the re-capitalization of the industry. This action added in excess of 2.4% to hospital

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[1] Equivalent Inpatient Admissions is a statistic that equals inpatient admissions plus an adjustment to include outpatient visits. It is used by the Commission to approximate volume increases across a hospital's entire operation (both inpatient and outpatient). It was also developed to measure performance on the basis of hospital cost per inpatient admission. Hospitals in Maryland and the U.S. do not segregate their costs into inpatient and outpatient areas. As a result, the EIPA statistic was developed to arrive at a measure that is mathematically equivalent to inpatient cost per admission. The HSCRC has also used this statistic to measure inpatient net operating revenue (NOR) per admission vs. the U.S. As such it is meant to measure **inpatient revenue per admission** (Maryland vs. the U.S.).

[2] Staff believes the intended 1.1% improvement over 3 years vs. the U.S. (an average of only 0.34% per year improvement) is completely achievable given the past ability of the rate system to generate efficiencies relative to hospitals nationally. During the 2001-2003 period (Maryland improved by 3.84% vs. the nation, an average of 1.28% per year) and over the period 1976 -1993, Maryland was able to grow more slowly than the U.S. by an average of 1% to 3% per year.

[3] See Trends Report in Health Affairs, October 3, 2006, Web Edition, pages 486-495 and Center for Health Systems Change, Paul Ginsberg, Data Bulletin 33.

[4] The Office of Management and Budget has estimated that the Medicare Trust fund will be insolvent by the year 2018 at current rates of expenditure growth.

revenues in addition to explicitly absorbing a needed realignment of rates (from outpatient to inpatient – see **Exhibit 1** at the back of this recommendation).[5]

Over the period FY 2004-2006, gross revenues increased 32% (an average of 10.8% per year) from $7.98 billion to $10.56 billion.[6] Volume growth accounted for 12% of this increase while significant rate infusions to the industry accounted for the remaining 20% increase (on average 6.71% per year).

As a result of these significant rate infusions and improved cost control by hospitals, total industry profits per the un-audited F/S schedules submitted to the HSCRC rose from 2.04% in 2003 to 4.56% in 2006. More recent financial information on Maryland hospitals shows an even more favorable profit picture for 2006 than was reported by the preliminary un-audited F/S data. The final HSCRC audited cost reports for the 41 hospitals with a June 2006 year-end resulted in total profits of 4.84%, in 2006, well above the Commission desired targets of 4.0%.

It should be noted that this total profit level of 4.84% was achieved even with the unanticipated increases in uncompensated care costs and prior to the restoration of budgeted case mix amounts for the industry. As a result of the "self-correcting" nature of the system, these amounts were restored to Maryland hospitals (a total of 1.48% additional rate updates) in FY 2007. Had these rate updates been matched to their incurred costs and infused in FY 2006, industry total profits for FY 2006 would have been 6.32%. Because these "catch up" amounts were added in FY 2007, industry profits should increase significantly this following year however. These are highly favorable results, and the industry and the Commission should be commended for this performance.

This was the "snapshot" of the industry presented the Commission when it approved the 1.1% improvement vs. the U.S. for the succeeding three years FY 2007-2009. The snapshot of the industry also included $10.86 billion in gross revenue, and total profits of approximately 4.84% (or 6.32% when adjusted on an accrual basis for significant FY 2007 rate infusions or "catch-up" amounts that were meant to cover costs incurred in 2006.

Staff believes this is the context for the Commission April 2006 action.

Rate Shift From Inpatient Rates to Outpatient Rates

After the Commission action in April of 2006, it became apparent that the system was not on the expected trajectory to hit the FY 2006 target of 2.0% below the U.S. on NOR/EIPA. There were two reasons for the slower than expected trajectory of the Maryland System 2004-2006.

First, uncompensated care (UC) and contractual allowances grew much faster than anticipated over this period. This meant that Net Operating Revenue (which reflects actual payments or operating revenue) was increasing less rapidly than gross revenues (charges), which are controlled by the Commission. This is

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[5] Note: there have been three large-scale shifts of revenue across the inpatient and outpatient sectors. The first (**Rate Realignment 1**) was accomplished over the period FY 2001-2003 based on a negotiation with the industry to allow outpatient rates to grow more rapidly than inpatient rates during this period. This resulted in a shift of about 1.24% from inpatient revenues to outpatient – causing a mis-alignment of rates to underlying costs. To correct this mis-alignment, the staff explicitly called for a reversal of this 2001-2003 shift (**Rate Realignment 2**) in the second three year rate arrangement FY 2004-2006. This shift back to inpatient was largely accomplished in FY 2004. These two shifts were policy calls by the staff and the Commission and are inextricably tied together. The third shift (**Rate Realignment 3**) was accomplished unintentionally when the rates of JHH and UMMC were recalibrated after experiencing large DRG creep and large unsubstantiated increases in measured case mix. This third shift should not be counted against the first two rate realignments.

[6] These are gross revenues as reported on the monthly Monitoring Maryland Performance report issued by the HSCRC. Net revenues increased slightly less over this period – approximately 29% resulting in overall net revenues for the industry of $9.22 billion as shown in Table 2 shown later in this document.

largely a timing issue. The newly adopted HSCRC Uncompensated Care policy will result in restoration of these increased UC amounts in FY 2007.

econd, so-called "case mix creep" (significant coding enhancements leading to measured case mix growing far in excess of actual resource use for Johns Hopkins Hospital (JHH) and University of Maryland Medical Center (UMMC) during the transition to APR-DRGs 2002-2004) lead to a recalibration of these hospitals' unit rates, which in turn, shifted over 1.0% of total Maryland system revenue from inpatient rates to outpatient rates.

This shift has been referred to as a "realignment of rates," but it is not characteristic of the normal rate realignment that occurs in the Rate Setting System as a matter of course each year. The 1.0% shift from inpatient targets and revenue to outpatient rates and revenue came about largely as a result of a technical adjustment to the rates of the Academics. It related to a correction of a growing disconnect between unit rates and each hospital's approved Charge per Case (CPC), as a result of the increases in measured case mix under APR-DRGs.[7] Staff believes this circumstance was largely caused by the significant case mix "creep" experienced by these facilities during the years FY 2002-FY 2004.

Normally, a hospital's unit rates (approved rate per day, rate per OR minute, rate per procedure or rate per test) times their reported volume of units (days, OR minutes, procedures or tests, etc.) deliver overall inpatient revenue that is consistent with its case mix adjusted CPC times its number of inpatient admissions. As a hospital's CPC increases because of increases in case mix (sicker patient requiring more services), the hospital has the ability to increase its unit rates to allow it to recoup the necessary revenue to cover these increases in services. However, if a hospital is treating sicker patients (all other things being equal), one should also expect to see an increase in services provided or overall volumes of days, minutes, and tests.

ı the case of the these academic institutions, the APR-DRG case mix grouper indicated much higher case mix (sicker patients requiring more services), yet the amount of services per patient, as measured by the number of days, OR minutes, procedures and tests, was actually falling. In order to generate the inpatient dollars to meet their approved case mix adjusted CPC, JHH and UMMC, in accordance with Commission protocol, dramatically raised their room rates. However, this increase in room rates was not associated with a commensurate increase in resource use and cost. This circumstance was highly indicative of coding creep – a practice whereby a hospital can materially and positively affect its case mix measurement by optimizing case mix coding from one year to the next.

Under this recalibration, the revenue generated by those much higher room rates was then spread throughout the hospital, including to centers that apply to both inpatient services and outpatient services (this includes operating room, ancillary, clinic and Emergency Room rates). This shift was revenue neutral at the hospital and payer levels – that is, while outpatient rates rose, each hospital's CPC and inpatient rates declined. At the moment this adjustment occurred, the hospitals neither gained nor lost revenue through this adjustment, and the payers neither paid neither more nor less as a result of this adjustment.

Timing and Failure to Identify the Shift to Outpatient Rates

As noted, the realignment shift did result in a commensurate increase in outpatient rates (and revenue) and lowering in inpatient CPCs, rates, and revenues. This latter circumstances is important because it had the effect of lowering the trajectory of inpatient revenue per case (NOR/EIPA), while overall revenue in the

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Again, these measured increases were not substantiated by commensurate increases in actual resource use over this period. Instead they were and characteristic of a move to a highly sensitive case mixing system (APR-DRGs), and appeared to be primarily driven by significant enhancements in coding activities of these hospitals. The potential for this phenomenon is well documented in current health services literature and is an item of significant concern to the Center for Medicare and Medicaid Services (CMS) as they work to transition their system to a severity adjusted case mix grouper.

system remained the same. This circumstance, however, resulted in the Maryland Rate System "looking better" under its NOR/EIPA target vs. the U.S. than expected, while the public was paying precisely the same amount as before (just now split a little differently between inpatient and outpatient revenues).

These rate recalibrations were requested by the academic hospitals and the Commission (to correct the so-called "disconnect" in rates and CPC). Staff failed to recognize the impact of this shift during the deliberations of the Payment Work Group. In retrospect, the impact of these technical adjustments should have been incorporated into the discussions and negotiations.

Impact of the Outpatient Shift

If this circumstance is not accounted for, the system will now be allowed to charge an additional 1.0% of revenue relative to what was approved by the Commission when it voted to improve vs. the nation by 1.1% over the period FY 2007-2009. This is because Maryland's position on NOR/EIPA now only "appears" 1.0% more favorable than when the Commission was deliberating over the FY 2007-2009 rate target. In fact, all other circumstances are the same as in April 2006. The system has the same level of revenue resulting in the same healthy level of profitability (4.84% total margin in 2006 or 6.32% when adjusting for "catch up" amounts realized in 2007). However, the shift of revenue from outpatient to inpatient resulted in a "paper" increase in the number of EIPAs in the system and artificially lowered Maryland's NOR/EIPA measure – the measure that we use to compare ourselves vs. the nation.

An analogy might be – that in a pool of water with a shallow end (outpatient) and a deep end (inpatient), 1.0% of the total water in the pool was somehow shifted from the deep end to the shallow end in period 1. The total amount of the water in the pool is the same in period 1, but the water levels in each end now are different (the deep end level is down and the shallow end level is up). However, because we only use the level in the deep end (NOR/EIPA, which is an inpatient measure) for purposes of measuring the appropriate level of the total water in the pool, we now "think" that we can add 1.0% more water to the pool in periods 2 and 3. Yet doing this, (at the end of the current three year period) will result in 1.0% more water in the pool, than appropriate.

In the context of the current three year deal, Maryland NOR/EIPA (an inpatient measure) is artificially depressed by 1.0% because of the shift to outpatient. So, relative to the original 3.1% below target, we might think we can add 1.0% more revenue to the hospital system. However, this 1.0% revenue is already being charged to the paying public, and the failure to recognize the overall level of charges (in and out) will indeed result in charging the public an additional 1.0%.

Not accounting for the shift will result in:

1) an artificial increase in the number of reported EIPAs beyond what was factored in by the Commission at the April 2006 decision;
2) a resulting artificially lower NOR/EIPA measure for Maryland vs. the nation; and
3) more apparent "room" under the Commission adopted target (a target adopted in the absence of information regarding this circumstance);

This artificially lower NOR/EIPA amount for Maryland will result in much larger updates for FY 2008 and FY 2009, or over $150 million additional charges to the public over what staff believes was intended by Commission action in April 2006.

Table 1 below shows the result of this artificial improvement vs. the U.S. on NOR/EIPA and the accompanying impact on rate updates (given the staff's recent reforecast of U.S. performance – see Table 3

below), the impact on our position vs. the U.S., the impact on additional hospital charges to the public and the impact on industry profitability

Table 1 : Impact of Accounting for or Failing to Account for 1.0% Outpatient Shift

Scenario 1
EIPAs, NOR/EIPA and Md. vs. U.S. Position
When not adjusting for Outpatient Shift

	A	B	C	D	E	F	G	H
	$s in Billions							
	Inpatient Revenue	Outpatient Revenue	Total Revenue	EIPAs	Maryland NOR/EIPA	Md. vs. U.S. NOR/EIPA	Update Factor	Total Profit Margin
FY 2006	$6.541	$2.888	$9.429	965,995	$9,760	−3.40%	6.99%	4.84%
FY 2007	$7.037	$3.159	$10.197		$10,306	−4.07%	5.59%	6.80%
FY 2008	$7.629	$3.456	$11.085		$10,967	−3.73%	6.41%	7.44%
FY 2009	$8.271	$3.781	$12.052		$11,670	−3.10%	6.41%	8.11%

Scenario 2
Staff Recommendation
EIPAs, NOR/EIPA and Md. vs. U.S. Position
When adjusting for Outpatient Shift

	A	B	C	D	E	F	G	H
	$s in Billions					Adjusted (1)		
	Inpatient Revenue	Outpatient Revenue	Total Revenue	EIPAs	Maryland NOR/EIPA	Md. vs. U.S. NOR/EIPA	Update Factor	Total Profit Margin
FY 2006	$6.684	$2.745	$9.429	956,150	$9,726	−2.39%	6.99%	4.84%
FY 2007	$7.191	$3.003	$10.195		$10,414	−3.08%	5.59%	6.80%
FY 2008	$7.742	$3.286	$11.027		$11,002	−3.42%	5.65%	7.19%
FY 2009	$8.333	$3.595	$11.928		$11,622	−3.49%	5.64%	7.45%

Differences Between Scenario 1 & Scenario 2

	H	I	J	K	L	M
		w/o Adj.	w/ Adj.		w/o Adj.	w/ Adj.
	Millions $ Revenue Difference	Update Factor Scenario 1	Update Factor Scenario 2	Difference in Update Factors	Improvement or (Erosion) in position Md. vs U.S. Scenario 1	Scenario 2
FY 2006	$0.00	6.99%	6.99%	0.00%	N/A	N/A
FY 2007	$0.00	5.59%	5.59%	0.00%	0.68%	0.68%
FY 2008	**$58.2**	6.41%	5.65%	0.76%	−0.34%	0.35%
FY 2009	**$124.4**	6.41%	5.64%	0.77%	−0.63%	0.07%
Totals	**$182.5** Million			1.53%	**−0.30%**	**1.10%**

Estimate of additional Charge to the Public When failing to adjust for the O/P Shift vs. what was Approved by the HSCRC April 2006

Under this Scenario, w/o adjustment the System erodes −0.30%

Under the Staff Recommendation the System Improves by 1.1% per the April 2006 Commission action

Re-initiation of the Payment Work Group and Staff Updating the Maryland Forecast

At the direction of the Commission, the staff reinitiated the Payment Work Group over the months of November and December 2006 to discuss the above circumstance. In the process of these deliberations, additional information and data on Maryland's performance vs. the U.S. became available from the following sources:

1) the definitive American Hospital Association (AHA) statistical guide for FY 2005 were released in November. It showed that the U.S. grew slightly slower than forecasted by staff in FY 2005 (5.24% annual growth vs. 5.80% forecasted by staff);

2) the Colorado Hospital Association (CHA) data base (a survey sample of some 800 hospitals nation-wide) tracking the performance of U.S. cost and revenue growth in 2006 became available in December. This survey tool tracks very closely with the final AHA statistical guide when it is released a year later. As a result, the Colorado Hospital Association survey is a useful check on the U.S. a year prior to the actual release of the final and definitive AHA data guide. This CHA interim survey showed the U.S. growing much more rapidly in 2006 than forecasted (7.3% annually growth revenue per case vs. a 5.65% forecast by staff);

3) The HSCRC compiled its annual cost data for 41 of its 47 hospitals (those having a June 2006 fiscal year end). This data showed that Maryland appeared to be growing faster than expected in FY 2006 in revenue per case (6.48% vs. 5.67% originally forecast).

Based on these new data, staff updated and re-forecasted Maryland's position vis-a-vis the U.S. for FY 2006 through FY 2009.

Staff Re-Forecast and Staff Recommendations

Based on these new data it appears that the U.S. is indeed increasing more rapidly than was originally expected in FY 2006. Accordingly staff has revised its FY 2006 estimate for increases in NOR/EIPA for the U.S. to 7.0% and also increased its forecasted rates of growth for the out years FY 2007 – 2009 proportional amounts (these staff forecasts do reflect a moderating trend from the FY 2006 growth given the economic un-sustainability of current hospital cost trends. However, the current staff forecasts for FY 2007-2009 reflect upward adjustments from the original staff forecast.

Table 2 on the next page shows the results of the staff's re-forecast of the situation nationally.

Table 2 – Reforecasted Performance Maryland vs. U.S. Under Two Scenarios

Scenario 1: No Adjustment for O/P shift

Reflects a 0.30% erosion ----->

UNADJUSTED	AHA Actual		AHA Actual		Note (1)		Not Adjusted for O/P shift				
Net Operating Revenue (NOR)/EIPA	2004		2005		2006		2007		2008		2009
US Hospitals (per AHA)	$8,975	5.24%	$9,445	6.97%	$10,104	6.34%	$10,744	6.03%	$11,392	5.72%	$12,043 (1)
Maryland (per AHA)	$8,563	5.58%	$9,041	7.96%	$9,760	5.59%	$10,306	6.41%	$10,967	6.41%	$11,670
Maryland Above/Below	−4.59%		−4.28%		−3.40%		−4.07%		−3.73%		−3.10%

Note: Reforecasted U.S. rates of Growth
Based on recent Colorado Hospital Association Survey

Constitutes a 0.30% Erosion
in our position vs. the U.S.

Scenario 2: Adjustment for O/P shift

Reflects a 1.1% Improvement --->

ADJUSTED	AHA Actual		AHA Actual				Adjusted for O/P shift				
Net Operating Revenue (NOR)/EIPA	2004		2005 (1)		2006 (1)(2)		2007		2008		2009
US Hospitals (per AHA)	$8,975	5.24%	$9,445	6.97%	$10,104	6.34%	$10,744	6.03%	$11,392	5.72%	$12,043
Maryland (per AHA)	$8,563	5.58%	$9,041	7.96%	$9,862	5.59%	$10,413	5.65%	$11,002	5.64%	$11,622
Maryland Above/Below	−4.59%		−4.28%		−2.39%		−3.08%		−3.42%		−3.49%

Note: (1) Maryland position for FY 2006 adjusted for accrual or "catch−up" amounts infused in FY 2007 but associated with FY 2006 cost
(2): Maryland position for 2005 and 2006−2009 adjusted for impact of 1.0% shift

Profitability under Scenario 2 (Staff Recommendation)	Regulated/Unregulated June YE F/S 2006	Regulated/Unregulated June YE RE Hosp 2006	HSCRC Targets	Projected Profitability 2007	Projected Profitability 2008	Projected Profitability 2009
Operating Profits	2.86%	2.98%	**2.75%**	5.28%	5.75%	6.07%
Total Profits	4.56%	4.84%	**4.00%**	6.80%	7.19%	7.45%
		Note 3				

Note (3): June Year end 2006 audited cost report data for 41 Maryland hospitals shows a 4.84% profit

The table and chart that follow compare the update factors and system trajectory (performance vs. the U.S.) under each of the two previously discussed scenarios.

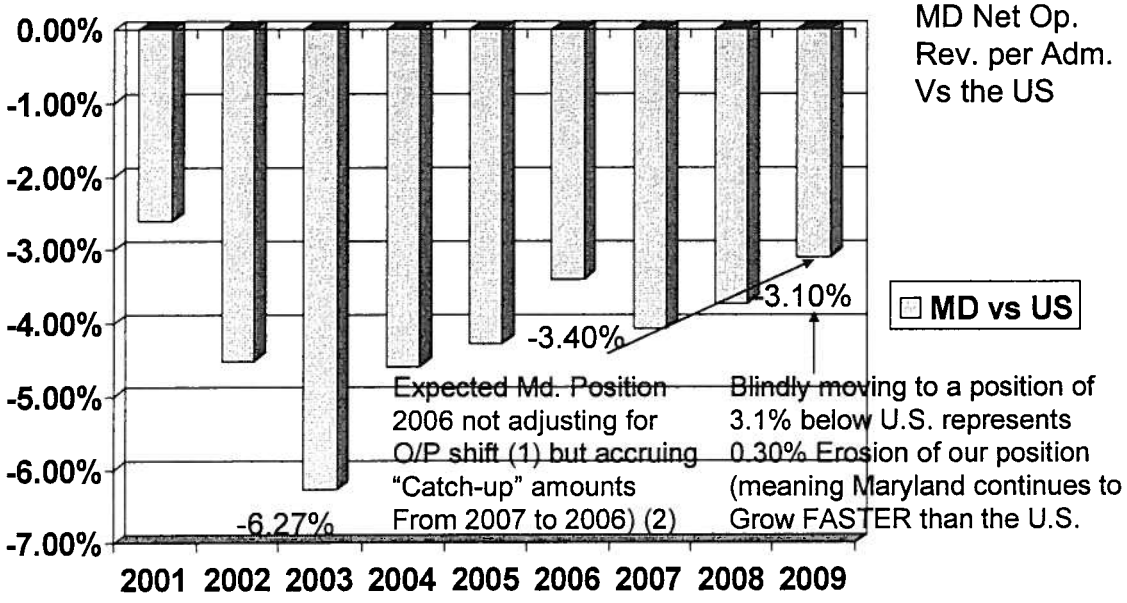
Table 3 – Comparison of CPC total Update Amounts
(Original Commission approved update April 2006, Revised Staff recommended updates 2007 – with and without an accounting for the 1.0% shift to outpatient)

	2007	2008	2009
Commission approved April 2006 Updates	5.21%	5.36%	5.26%
Re-forecasted Staff recommended 2007 Updates with 1.0% Adjustment	**7.07%**	**5.65%**	**5.64%**
Re-forecasted Staff 2007 Updates with no 1.0% Adjustment	7.07%	6.41%	6.41% (1)

Note (1): No adjustment for the 1.0% shift results in updates that cause Maryland to ***Erode*** vs. the U.S. over the period FY 2007-2009

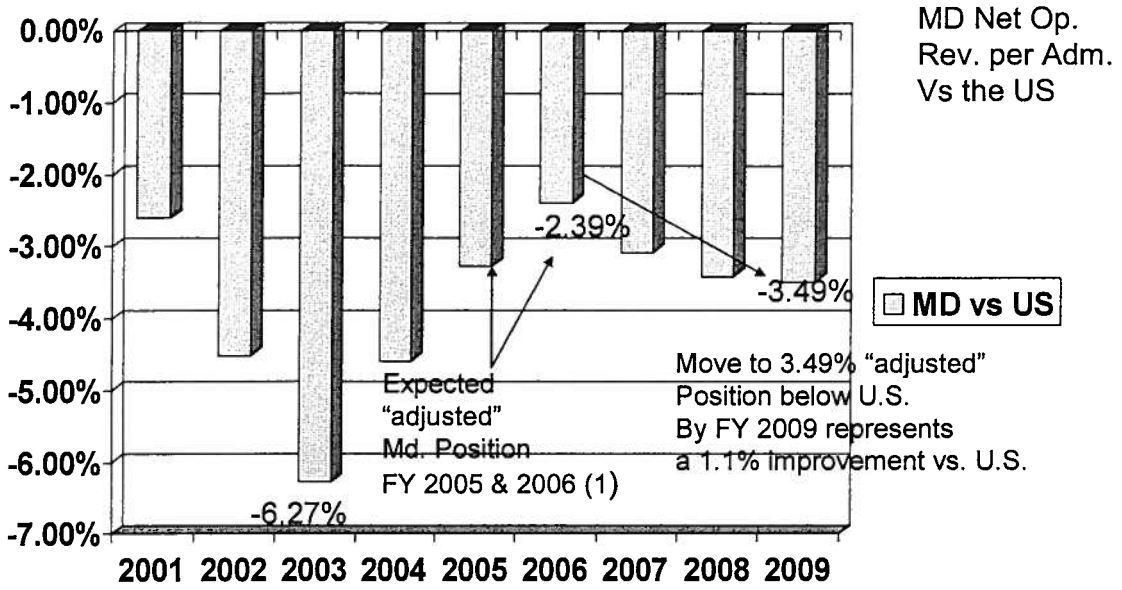
Scenario 1:

"Blindly" move to 3.1% target: Erode by 0.30% vs. the U.S.



Note (1): Maryland's 2006 position not adjusted for impact of outpatient shift
(2) Maryland 2006 position adjusted for 1.48% "catch-up" infusion in 2007 associated with FY 2006 costs.

Scenario 2
Staff Recommendation:
Improve 1.1% vs. the U.S. FY2007-2009



Note (1): Maryland's 2005 & 2006 position adjusted for impact of outpatient shift & FY 2006 position adjusted for 1.48% "catch-up" infusion in 2007associated with FY 2006 costs.

The Table and the charts above show the substantial increases in U.S. NOR/EIPA growth in FY 2006 will result in large (and commensurate) increases in Maryland update factors for FY 2008 and FY 2009 far in excess of what was anticipated in April of 2006. The Table also shows the massive updates that would result if the Commission chose to ignore the impact of the unanticipated 1.0% shift to outpatient rates discussed above. This latter scenario would reflect a "blind" adherence to a final goal of 3.1% below the U.S. on the basis of NOR/EIPA by FY 2009 (as advocated by the Maryland Hospital Industry). This scenario would also result in the Commission approving annual updates that would cause Maryland to actually *grow faster* than the U.S. in FY 2008 and FY 2009. This is not the result intended by the Commission in April when it approved a rate arrangement that anticipated a modest Maryland improvement (by historical standards) vs. the U.S.

Simultaneously, this scenario that fails to account for the 1.0% shift ignores several key policy considerations:

The U.S. Growth Rates are Out of Control
The U.S. was thought to be growing quite rapidly over the current period; now we know the U.S. is growing even more rapidly and is by all accounts out of control. These growth rates are likely driven by the monopolistic control now acquired by many hospitals and hospital systems across the country;

Affordability of Hospital Care should be a Higher Priority
The issues of reduced affordability of health care generally and hospital care are even more acute than originally expected and this more rapid growth will significantly contribute to increases in the number of uninsured in the nation;

Commission Policy for the FY 2004-2006 Rate Deal Authorized an Adjustment for Rate Realignment
As articulated in the staff recommendation to the Commission dated October 2006, the staff recommendation approved by the Commission in 2003 regarding the FY 2004-2006 rate arrangement explicitly authorized an adjustment to the Maryland NOR/EIPA target for the issue of rate realignment. Rate realignment in this rate arrangement was meant to be budget neutral for the system. The current staff recommendation is consistent with this approved policy and moreover results in the most recent realignment being budget neutral for the system.

Staff's has been Consistent in its Approach from 2001 to the Present Period
Also as articulated in the October 2006 staff recommendation, the current staff approach reflects a pragmatic and balanced evaluation of the current facts and circumstances. Staff has been consistent in pursuing this approach in the past as evidenced by its recommendation in 2001 to add nearly 1.0% to hospital rates to account for unanticipated increases in underlying hospital costs. This action may have literally "violated" the previously agreed upon rate arrangement FY 2001-2003, but was appropriate and defensible given a pragmatic and balanced evaluation of the facts and circumstances at the time. For regulation to work, it needs to be fair and balanced and work in both directions in a consistent fashion.

The Current Update Factors are far above those forecasted in April 2006
The re-forecasted staff recommended updates for FY 2008 and FY 2009 (after properly adjusting for the 1.0% shift) on top of huge update for Maryland hospitals in FY 2007 of over 7.0% will be more than adequate to allow for continued increases in profitability in Maryland and a completion of the needed recapitalization of Maryland hospitals (which has to date resulted in over $5.0 billion of approved or "in-the pipeline" construction projects per the MHCC). "Blind" adherence to previously agreed upon numbers (disregarding all current facts and circumstances) would result in the Commission approving those earlier rate updates ranging from 5.21% to 5.36% over the period FY 2007-2009 (shown on Table 1). Staff is not recommending this. It is recommending that updates be increased, but that Maryland also do what a rate-regulated can and should do, which is to improve vs. a national situation that is completely broken.

The Commission has Delivered on its Pledge to Facilitate the Recapitalization of the Industry
Given these circumstances, staff believes it is even more vital that the Commission recognize that it has followed through on its pledge to facilitate the recapitalization of the Maryland hospital industry. This effort (with the support of the hospital industry in successfully controlling their costs over the period FY 2004-2006) will result in an unprecedented increase in Maryland construction and capital expenditures. Bond ratings have been substantially improved, and the rating agencies view the Maryland financial situation in the most favorable light ever. Profitability of the industry will continue to increase even if the industry starts to experience increased wage pressure in the coming years (alleged by the MHA but not demonstrated empirically). The Commission has delivered on its pledge to facilitate the recapitalization of the industry; profits will continue to increase and the unprecedented recapitalization of in excess of $5.0 billion over the Period FY 2004-2010 will indeed occur.

Table 4 – Projected Impact on System Profitability under Scenario where 1.0% shift to Outpatient is and is not Accounted for FY 2007-2009 (also shown on Table 1)

Without Accounting for O/P Shift

	Target	Actual	Projected (1)		
		2006 F/S	2007	2008	2009
Operating Margin	2.75%	2.86%	5.28%	6.00%	6.75%
Total Margin	4.00%	4.56%	6.80%	7.44%	8.11%

Update Factor for FY 2007 includes 1.48% "Catch-up" amount associated with costs incurred in 2006

Table 4 - Continued

Accounting for O/P Shift

	Target	Actual	Projected (1)		
		2006 F/S	2007	2008	2009
Operating Margin	2.75%	2.86%	5.28%	5.75%	6.07
Total Margin	4.00%	4.56%	6.80%	7.19%	7.45%

Update Factor for FY 2007 includes 1.48% "Catch-up" amount associated with costs incurred in 2006

Audited June YE Hospitals Profit = 4.84% for 2006

Note 1: These projections are based on the MHA financial forecast model presented to the Commission March 2006. Staff adjusted this forecast for two inaccurate assumptions relating to: 1) MHA assumption that measured cost associated with measured case mix is 100% variable (staff believes case mix creep = 0% variable cost and real case mix = 85% variable cost) and 2) MHA assumption that outpatient volumes are growing at 3.0% when they are currently growing at 6-8%. The projections also assume cost constraint similar to that achieved in 2006 and take into consideration the "catch-up" amounts of 1.48% related to FY 2006 costs but infused into rates in FY 2007. As such the assumed profit of 6.80% for FY 2007 is quite credible.

Draft Staff Recommendations

1) The Commission accept the re-forecasted staff modeling and update factors (adjusted for the revenue impact on the public of the 1.0% shift to outpatient rates);

2) The Commission defer to the Hospital industry and adopt its preferred approach for how to distribute the previously unallocated case mix from FY 2006 in the rates of hospitals during the course of FY 2007. This would constitute allocation of case mix based proportionately on the measured case mix (before application of the HSCRC's case mix calibration or "governor"). Staff accepts this preference of the industry.

Exhibit 1: Rate Realignment

Three Rate Realignments or I/P – O/P Shifts over Fy 2001–2006

These two Rate Realignments are inextricably Linked by Policy Decisions

RR 1 | RR 2

2001 | 2002 | 2003 | 2004 | 2005 | 2006

Rate Realignment 1
Negotiated arrangement to allow O/P rates to grow faster than I/P rates. Part of the First 3 year Rate Arrangement
This shifts 1.24% from Inpatient to Outpatient rates ---------->

1.24% <---------> **1.24%**
In to Outpatient shift
Neutralized by Policy Action of the Commission in 2003 to shift back from Out to Inpatient

It results in an improvement in the position of Maryland vs. the U.S. on NOR/EIPA

The 1.24% shift from Inpatient to Outpatient in 2001–2003 is completely offset by the policy decision in 2003 to shift back to Inpatient rates by the same magnitude 1.24%

This results also in a mis–alignment Outpatient Rates to Outpatient Costs (contrary to HSCRC Statute).

Rate Realignment 2
Staff Recommended and adopted, to reverse the impact of RR 1. This action shifts 1.24% back from Outpatient to Inpatient ---------->

This results in an erosion in Maryland's position on NOR/EIPA but Hospitals accept this because the Staff also recommends infusing an additional 2.4% into rates.

RR 3

1.01%

Shift from Inpatient to Outpatient

RR 3 – Third Shift: 1.01% Inpatient to Outpatient shift currently being discussed is not related to RR 1 or RR 2.

It results in an "artificial" improvement in Maryland's NOR/EIPA.

MHA falsely equates RR 2 with RR 3 to attempt to show that the effect of Rate Realignments is budget neutral. This is not correct, RR 3 will result in the Public being charged 1.0% more what was intended by the April 2006 staff recommendation and Commission action.